State of California—Health and Human Services Agency

Department of Health Services
Office of AIDS
HIV/AIDS Surveillance Program

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≥ 13 years of age at time of diagnosis)

Date form completed: Month / Day / Year

Report status: 1 New; 2 Update

I. Health Department Use Only

Report source | Reporting health department | State patient number | City/county patient number

II. For HIV and AIDS Cases

Soundex code | Date of birth (Month / Day / Year) | Gender: 1 M; 2 F; 3 M→F; 4 F→M

For Non-AIDS Cases Only

Last four digits of SSN | Lab report number | *Confidential C&T number

*Publicly funded confidential counseling and testing sites only

III. Demographic Information

Diagnosis status at report (check one) — Age at Diagnosis Years
- 1 HIV infection(not AIDS)
- 2 AIDS

Current status: 1 Alive; 2 Dead; 9 Unknown

Date of death (Month / Day / Year)

State/Territory of death

Race/Ethnicity: 1 White (non-Hispanic); 2 Black (non-Hispanic); 3 Hispanic; 4 Asian/Pacific Islander; 5 American Indian/Alaska Native; 9 Not specified

Country of birth: 1 U.S.; 7 U.S. Territories (including Puerto Rico); 8 Other (specify): _____; 9 Unknown

☐ Check if HIV infection is presumed to have been acquired outside United States and Territories. Specify country: _____

Residence at diagnosis: City | County | State/Country | ZIP code

IV. Facility of Diagnosis

Facility name

City

State/Country

Facility type (check one)
- 01 Physician, HMO
- 29 Community Health Center
- 30 Correctional Facility
- 31 Hospital, inpatient
- 32 Hospital, outpatient
- 88 Other (specify): _____
- 99 Unknown

Facility setting (check one): 1 Public; 2 Private; 3 Federal; 9 Unknown

V. Patient History

After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (respond to ***ALL*** categories):

	Yes	No	Unknown
• Sex with a male	1	0	9
• Sex with a female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

Specify disorder: 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (specify): _____

• HETEROSEXUAL relations with any of the following:	Yes	No	Unknown
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/components (other than clotting factor) First: Month / Year; Last: Month / Year	1	0	9
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health care or clinical laboratory setting (Specify occupation): _____	1	0	9

VI. Laboratory Data

A. HIV Antibody Test at Diagnosis *(Indicate first test.)*

	Pos	Neg	Ind	Not Done	TEST DATE Month	Year
• HIV-1 EIA	1	0	—	9		
• HIV-1/HIV-2 combination EIA	1	0	—	9		
• HIV-1 Western Blot/IFA	1	0	8	9		
• Other HIV antibody test (Specify): _____	1	0	8	9		

B. ***Positive*** HIV Detection Test *(Record earliest test.)* — Month / Year
☐ Culture ☐ Antigen ☐ PCR, DNA, or RNA probe
Other (specify): _____

C. ***Detectable*** Viral Load *(Record earliest test.)* — Month / Year
Test type* ____ Copies/ml ____,____,____

*Type 11=NASBA (Organon); 12=RT-PCR (Roche); 13=bDNA (Chiron); 18=Other

- Date of last documented ***negative*** HIV test (specify type): _____ — Month / Year
- If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? — Yes / No / Unknown: 1 / 0 / 9
- If yes, provide date of documentation by physician — Month / Year

D. Immunologic Lab Tests

At or closest to current diagnostic status
- CD4 count ____,____ cells/µl — Month / Year
- CD4 percent ____ %

First <200 µl or <14%
- CD4 count ____,____ cells/µl — Month / Year
- CD4 percent ____ %

STATE/LOCAL USE ONLY

VII. *FOR AIDS CASES ONLY—Patient-identifier information is not transmitted to CDC.*

Patient's name (last, first, MI) | Telephone number ( ) | Social Security Number

Address (number, street) | City | County | State | ZIP code

VIII. Clinical Status

Clinical record reviewed — Yes [1] No [0]

Enter date patient was diagnosed as — Month / Year
- Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy) .....
- Symptomatic (not AIDS) .....

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Month	Initial Date Year
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Carcinoma, invasive cervical	1	NA		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 month duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 month duration)	1	NA		
Kaposi's sarcoma	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
M. tuberculosis, pulmonary	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis carinii pneumonia	1	2		
Pneumonia, recurrent, in 12-month period	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Salmonella septicemia, recurrent	1	NA		
Toxoplasmosis of brain	1	2		
Wasting syndrome due to HIV	1	NA		

Def.=definitive diagnosis *Pres.=presumptive diagnosis*

*RVCT case number

If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? Yes [1] No [0] Unknown [9]

IX. Treatment/Services Referrals

	Yes	No	Unknown
Has the patient been informed of his/her HIV infection?	1	0	9

This patient's partner(s) has been or will be notified about their HIV exposure and counseled by:
[1] Health Department [2] Physician/Provider [3] Patient [9] Unknown

This patient received or is receiving:	Yes	No	Unknown
• Antiretroviral therapy	1	0	9
• PCP prophylaxis	1	0	9

This patient is receiving or has been referred for:	Yes	No	NA	Unknown
• HIV-related medical services	1	0	—	9
• Substance abuse treatment services	1	0	8	9

This patient has been enrolled at:

Clinical Trial	*Clinic*
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:
[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other public funding
[7] Clinical trial/government program [9] Unknown

For women:	Yes	No	Unknown
• This patient is receiving or has been referred for gynecological or obstetrical services	1	0	9
• This patient is currently pregnant	1	0	9
• This patient has delivered live born infant(s)	1	0	9

(If yes and if delivered after 1977, provide birth information below for the most recent birth)

Child's date of birth (Month / Day / Year)	Hospital of birth / City	State	Child's Soundex	Child's state patient number

X. Comments

Persons with HIV infection without an AIDS diagnosis must be reported without name. Persons with conditions meeting AIDS case criteria must be reported with name. For additional information about HIV/AIDS case reporting, please call your local health department.

XI. Provider Information

Physician's name (last, first, MI)	Telephone number ( )	Patient's medical record number	Person completing form	Telephone number ( )

Address (number, street)	City	State	ZIP code

MAIL COMPLETED FORM TO YOUR LOCAL HEALTH DEPARTMENT.